ADULT ATTACHMENT AND ITS CLINICAL IMPLICATIONS

WORKING WITH ATTACHMENT DYSFUNCTION IN PRACTICE

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LEARNING OBJECTIVES

- Understand the relevance of Adult Attachment to psychological practice
- Identify similarities and differences between Child and Adult Separation Anxiety
- Explore how Adult Attachment influences close relationships and mental health outcomes
- Recognise and assess for Adult Separation Anxiety Disorder (DSM-5) in clinical practice

LEARNING OBJECTIVE (CONTD.)

- Understand how the Adult Separation Anxiety questionnaire (ASA-27) can be used in clinical assessment
- Gain practical skills in interpreting and integrating the ASA-27 results into psychological formulations

SPECIFIC TOPICS

A. How does Separation Anxiety relate to Attachment and Attachment Theory?
B. What is the relationship between Separation Anxiety (SA) and the development of Separation Anxiety Disorder (SEPAD)?
C. What are the differences between child and adult versions of the disorder?
D. How does Adult Separation Anxiety Disorder manifest in clinical practice?
E. Assessing Separation Anxiety and Separation Anxiety Disorder in adults using the ASA-27

HOW DOES SEPARATION ANXIETY RELATE TO ATTACHMENT THEORY?

A BRIEF REVIEW OF ATTACHMENT THEORY

- There are several ‘innate’ fears common to most mammalian species
- These fears manifest at an early stage of development and vary in intensity between species and between individuals of the same specie
- In humans, these fears can include loud noises, the sensation of falling, fears of strangers, the dark, and separation from a parent/caregiver
- In humans and many other mammals, separation distress is common (and normal) when juveniles are separated from their parents and vice versa

A BRIEF REVIEW OF ATTACHMENT THEORY (CONTD.)

- The drive to be close to caregivers who can afford protection when we are at our most vulnerable is a trait common to most mammalian species
- Over a period of time, **attachment styles develop and are shaped** by multiple factors including real or threatened separations from caregivers, temperament, and exposure to trauma or aberrant parenting styles (e.g. over-protection, over-control)
- Attachment styles are thought to have evolved to serve an adaptive function within a family or other social unit
- Evidence suggests continuity between attachment styles in childhood and adulthood

ATTACHMENT STYLES IN TODDLERS

- Ainsworth (1978) identified 3 attachment styles in infants and toddlers based on observations of separation and reunion responses in children when their mothers' left them for short periods of time
- The 3 attachment styles she identified were: Avoidant (Style A), Secure (Style B), and Ambivalent or Resistant (Style C)
- Main and Solomon (1986) later expanded this to include a disorganised/disoriented attachment style (Style D) for children who were unable to approach their caregivers after separation even if they were very distressed

‘PROTEST’ BEHAVIOURS IN TODDLERS

- Overt signs of separation distress in toddlers are unmistakable and readily interpreted by adults of all cultures
- When left even for a short period by their primary caretaker, infants and toddlers often exhibit a stereotypic distress reaction that manifests as obvious agitation, heightened motor activity, psycho-physiological arousal and, in many instances, crying and screaming

SEPARATION DISTRESS VS SEPARATION ANXIETY

- While protest behaviours are a feature of separation distress, separation anxiety implies a level of anticipation and cognitive processing regarding possible consequences
- Separation anxiety can be defined as an irrational fear of being separated from a close attachment or from places of safety
- The capacity to catastrophise or to draw from previous separation experiences can lead to high levels of separation anxiety
- Separation anxiety can be triggered by interpersonal conflicts, real and imagined future losses, and traumas or life events which trigger unpleasant memories

SEPARATION ANXIETY AND ATTACHMENT THEORY

- Separation anxiety (SA) is distinguished from other forms of anxiety in being most closely associated with Attachment Theory (See Ainsworth and Bowlby, 1991)
- SA is a central concept of developmental theory and is inferred rather than directly observed. **But** SA also refers to a set of operationalised symptoms and behaviours that can be observed and measured
- Aberrant Attachment Styles are thought to be associated with heightened SA
- Distinction between the dimensional concept of SA (that may be adaptive) and a categorical diagnosis of Separation Anxiety Disorder (which is maladaptive)

SA WITHIN THE CONTEXT OF OF ATTACHMENT AND PSYCHOANALYTIC FORMULATIONS

- Bowlby's Attachment Theory asserted that maternal overprotectiveness is instrumental in elevating SA levels in the child
- Bowlby also proposed that heightened early SA was a specific risk factor to the development of agoraphobia in early to middle adulthood i.e. SA-Ag model
- The Separation Anxiety-Agoraphobia (SA-Ag) model was extended to include panic disorder when that category was added to the diagnostic system in the early 80's (DSM-IV)
- This was a 'transformational model where SA manifested in a different form later in maturation, either as panic disorder, agoraphobia, or both
- This transformational model diverted attention from the recognition that SA symptoms could persist in an isomorphic form throughout life

SEPARATION ANXIETY (SA) AND THE DEVELOPMENT OF ADULT SEPARATION ANXIETY DISORDER (SEPAD)

HISTORICAL BACKGROUND

- Research began around 30 years ago to identify and codify the symptoms separation anxiety in adults
- Observations made by other clinical research groups around the world found similar results to our findings
- These findings indicated symmetry between the core features of SA in children and adults
- Core fears manifest as worry, physical symptoms, and reluctance to leave places of perceived safety such as the home
- Other features include restrictions in activities, and interpersonal difficulties arising from an excessive need to remain in close proximity (or contact) with close attachments

HISTORICAL BACKGROUND (CONTD.)

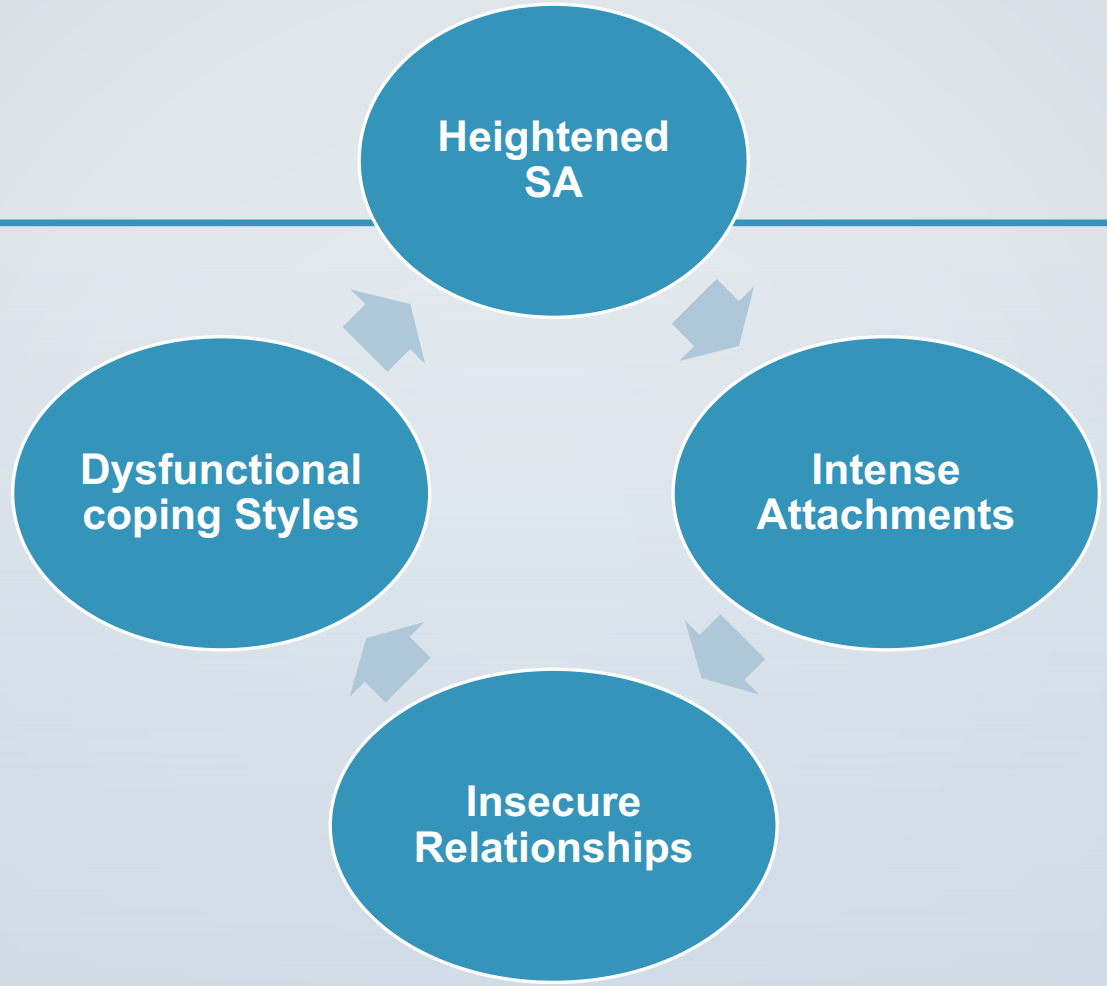
- Early enquiries led to the development of systematic measures of adult SEPAD which revealed a high prevalence of the disorder in outpatient clinics and in the general population
- This led to a re-conceptualisation of SEPAD from a disorder of childhood to one that could manifest throughout the life course - adopted in the DSM-5 and the ICD-11
- SEPAD is now one of the core subtypes of anxiety disorder, alongside other disorders such as panic disorder and agoraphobia, that can occur at all ages and throughout life

ADULT SEPARATION ANXIETY (SA) AND SEPARATION ANXIETY DISORDER (SEPAD)

- While adults are vulnerable to periods of SA during their lifetime (most notably following traumatic life events, significant losses, and major stresses), a smaller percentage are likely to develop adult SEPAD
- Correlations between high levels of adult SA and specific types of adult attachment styles have been inconclusive - suggesting that the two constructs are independent (Manicavasagar et al., 2009)
- Aberrant attachment styles can become entrenched in a self-reinforcing cycle mediated by SA

AETIOLOGY AND TRIGGERS OF SEPAD

- Risk for adult SA and aberrant attachment styles may share common aetiologies but they seem to be independent of one another
- Precursors to SEPAD include exposure to aberrant early parenting styles (overprotective, controlling and intrusive), traumatic separation events (parental loss or death), temperament and personality styles, genetic factors, dysfunctional intimate relationships (in adults)
- Heightened levels of SA are associated with unhelpful coping styles which, in turn, can impact on interactions with close attachments and further exacerbate SA symptoms
- SA symptoms can be ‘conditioned’ to environmental and social cues and, together with dysfunctional coping styles, lead to the diagnosis of SEPAD


Heightened SA
Intense Attachments
Insecure Relationships
Dysfunctional coping Styles

CHILDHOOD VS ADULT VERSIONS OF SEPARATION ANXIETY DISORDER

DIAGNOSTIC CRITERIA: DSM-5 AND ICD-11

- Revised definitions to re-conceptualize SEPAD from a disorder of childhood to one that that can occur throughout the lifespan
- SEPAD has been incorporated into the general section for the anxiety disorders in both DSM-5 and ICD 11 that can manifest throughout life
- Age of onset criterion removed – but symptoms should be present for at least four weeks in children and six months or more for adults in DSM-5
- No reference to parents or adults as the focus of anxiety; instead, the term ‘attachment figures’ is used throughout

INDICATORS OF CHILDHOOD SEPARATION ANXIETY

When separated from close attachments, protest behaviours in infants and young children (if prolonged and/or frequent) can coalesce into a pattern of emotional and behavioural problems which include:

- School refusal
- Avoiding sleep-overs at friends' homes
- Avoiding school excursions
- Physically 'clingy' behaviours towards care-givers
- Crying and tantrums when separated from care-givers

INDICATORS OF CHILDHOOD SEPARATION ANXIETY (CONTD.)

- In older children, SA behaviours may manifest in repeated phone calls, texts, or other forms of communication with close attachments to obtain regular reassurance about their whereabouts and activities when separation from them
- Older children may also display excessive reliance on their parents rather than peers for recreational activities and worry about the health and safety of parents
- They may experience ruminations and catastrophic thoughts about being separated from close attachments
- Self-referred fears of illness or incapacity which will separate them from their loved ones

PREVALENCE OF SEPAD IN CHILDREN

- Childhood SEPAD is a high prevalence disorder
- The 12-month prevalence is around 5% for childhood SEPAD, although estimates have varied across studies (ranging from 2% to 13%) (Costello and Angold, 1995; Cartwright-Hatton et al., 2006)
- Follow-up studies suggest that the prevalence of SEPAD decreases as children progress into adolescence and young adulthood
- In clinical practice, childhood SEPAD accounts for around half of all referrals of children to ambulatory clinics (Bell-Dolan, 1995; Cartwright-Hatton, et al., 2006; Last et al., 1987)

INDICATORS OF ADULT SEPARATION ANXIETY

- Seeking repeated and excessive reassurance about the availability of/contact with attachment figure(s) by frequently calling or messaging close attachments
- Insisting on the precise timing and conditions of reunions when separated from the attachment figure
- Reluctance to leave the home or finding excuses not to go out or to delay doing so
- Engaging in ‘sleep ‘rituals’ such as sleeping with the lights on or with the bedroom door open in order to hear the presence of other familiar people
- Seeking out key attachment figure(s), for example, by unnecessary or prolonged phone calls, or seeking out familiar people who are associated with their close attachment(s)

INDICATORS OF ADULT SEPARATION ANIXETY (CONTD.)

- Significant anxiety when leaving key attachment figure(s) to go to work or traveling for long distances
- Physical symptoms of anxiety such as gastric upset or nausea, or depressive symptoms when physically separated from key attachment figure(s) or when anticipating separation
- Inability to tolerate changes in usual routines
- Panic attacks or panic-like symptoms when separated from key attachment figure(s) or when anticipating separations
- Recurrent nightmares with themes of separation, violence, loss or abduction in relation to the self or close attachment figure(s)

INDICATORS OF ADULT SEPARATION ANXIETY (CONTD.)

- Ruminations or worries about key attachment figure(s) leaving the person or concerns of becoming separated in the absence of any real threat
- Excessive worries about harm befalling key attachment figure(s)
- Catastrophic thoughts about the effects on themselves of separations from key attachment figure(s)
- Concerns that their attachments to certain people may be too intense, and that the intensity of these attachments may affect their relationships with these people
- A reciprocal set of self-focussed fears involves unrealistic anxieties concerning their own health, safety and mortality when separated from major attachment figures

PREVALENCE OF SEPAD IN ADULTS

- The NCS-R epidemiological study in the USA interviewed around 5,500 people using a fully structured interview schedule (Kessler et al., 2005)
- Lifetime prevalence of SEPAD was higher in adulthood (6.6%) than in childhood (4.1%)(Shear et al., 2006)
- 76% of adults with SEPAD reported adult onset, usually by age 30 years (Shear et al., 2006)
- Adult SEPAD was more common than well-established forms of anxiety such as panic disorder (4.7%) or generalized anxiety disorder (5.7%)

PREVALENCE OF SEPAD IN ADULTS (CONTD.)

- Another more extensive epidemiological study of SEPAD interviewed 38,993 adults living in 18 countries participating in the WHO World Mental Health Survey (Silove et al., 2015)
- Lifetime prevalence of SEPAD was found to vary widely across countries but the pooled average was 4.8% (Silove et al., 2015)
- Two thirds of adults with SEPAD had their onset in adulthood
- Median age of onset of SEPAD was 27 years

ADULT SEPARATION ANXIETY DISORDER IN CLINICAL PRACTICE

CASE 1: KATIE

A 23-year-old office manager (Katie) with a 2-year history of anxiety referred for treatment of Panic Disorder. Symptoms intensified every time she had an argument with her partner or if he went out on his own without her. She was the only child of immigrant parents whom she described as overprotective and reliant on her. She had always lived at home and insisted that her partner move in with her.

Throughout her childhood and adolescence, Katie had found it difficult to sleep alone at night – often sleeping with her parents or with the lights on in her bedroom. She was anxious about leaving home to go to school or to work and worried about harm befalling her parents and later her partner whenever he left the house to go to work.

CASE 1: KATIE (CONTD.)

Six months prior to presenting at an anxiety clinic, her symptoms worsened, and she had to give up her work. She had discovered that her partner had been using drugs, and this provoked severe fears that he may die from an overdose. She resorted to accompanying her partner everywhere to keep an eye on him and this led to arguments and threats (by him) to leave the relationship. At this point, Katie developed panic attacks.

Treatment in a Panic Disorder group with a CBT focus did little to allay her anxieties as her symptoms fluctuated according to the stability of her relationship with her partner. Katie did not fulfil criteria for dependent personality disorder nor for any other personality disorder.

CASE 1: KATIE (CONTD.)

The onset of her Panic Disorder occurred subsequent to the exacerbation of her SA symptoms and no other psychiatric disorders were present.

CASE 2: MICHAEL

Michael, a 50 year-old successful business executive, presented for treatment due to a long-standing anxiety about travelling overseas on his own. His symptoms had recently worsened as his wife was under investigation for possible gynaecological cancer. Up till now, he had insisted that his wife accompany him on all overseas trips even if they were overnight. He also spoke to his two adult children every other day on the phone, even though they lived overseas.

His central worry was about being separated from those close to him and his fears of travelling were not due to any fears of flying but rather about being separated from his wife.

CASE 2: MICHAEL (CONTD.)

He was able to go to work in the city every day only if he knew his wife's exact whereabouts. He had not disclosed the extent of his fears to anyone else except his secretary who helped him find excuses for his inability to attend meetings or to travel on his own. He had been baffled by his anxieties as he felt they were not in keeping with his general level of self-confidence.

Michael described a disruptive childhood as his mother died when he was very young and he was brought up by a number of carers. His father suffered from alcoholism and when his father's second marriage ended, Michael and his brother were sent to boarding school.

CASE 2: MICHAEL (CONTD.)

Michael had tried a number of treatments in the past including antidepressant medications for the last 10 years. However, his response to medication management was suboptimal. He did not fulfil criteria for dependent personality disorder and his diagnosis had always been a mystery to his treating clinicians.

ASSESSING SEPARATION ANXIETY AND SEPARATION ANXIETY DISORDER IN ADULTS

RECOGNISING ADULT SEPARATION ANXIETY DISORDER

- SEPAD is often mistaken as other disorders such as PD-Ag, OCD, Health Anxiety, GAD
- However, conventional psychological management of these other conditions (e.g. CBT) rarely improves SA symptoms
- Recognition and management of underlying Separation Anxiety is relevant to treatment outcomes
- Patients are often reluctant or embarrassed to disclose their Separation Anxiety
- Referrals from GPs generally do not indicate adult Separation Anxiety Disorder

QUESTIONS TO ASK WHEN ASSESSING FOR SA IN ADULTS

- If high SA is suspected, ask about the circumstances surrounding the emergence of symptoms (e.g. precipitants, close attachments, impacts, etc.)
- Establish whether there is a pattern (triggers) to the repeated occurrence of episodes of heightened SA
- Ask specific questions about lifetime SA symptoms
- If SEPAD is indicated, ask about the consequences (impacts on the individual and on close attachments)
- Investigate associations between SEPAD and their current presentation?

WHY DO CLINICIANS MISS DIAGNOSING ADULT SEPAD?

- SEPAD shares symptoms with other (more familiar) anxiety disorders
- Symptoms may seem ‘normal’ to the clinician especially if some of those symptoms are shared by their clinician
- Clinicians’ reluctance to delve into unfamiliar territory in diagnosing and/or managing SEPAD
- Symptoms of other comorbid disorders may obscure adult SA symptoms
- Patients do not always volunteer the information that they suffer from adult SA symptoms

WHY DON'T PATIENTS REPORT ADULT SA SYMPTOMS?

- Patients may be used to living with this type of anxiety problem
- Patients may be embarrassed to report adult SA symptoms to clinicians
- Family/cultural factors may endorse adult SA and family members may act as 'enablers'
- Patients are more troubled by the symptoms of another comorbid disorder
- Patients only seek treatment for SEPAD when symptoms are severe

THE ASA-27 AS A MEASURE OF ADULT SA

- The ASA-27 is a 27-item self-report measure for adult separation anxiety (Manicavasagar et al., 2003)
- Attempts to capture the core features of SA in adulthood in a manner that is consistent with the construct underlying SEPAD in the DSM and ICD systems
- Taps into the behavioural, emotional and cognitive aspects of adult SA
- A unidimensional measure of adult SA i.e. there are no subscales
- Can be used as a pre- and post-treatment measure

USE OF THE ASA-27 TO ASSESS ADULT SEPARATION ANXIETY

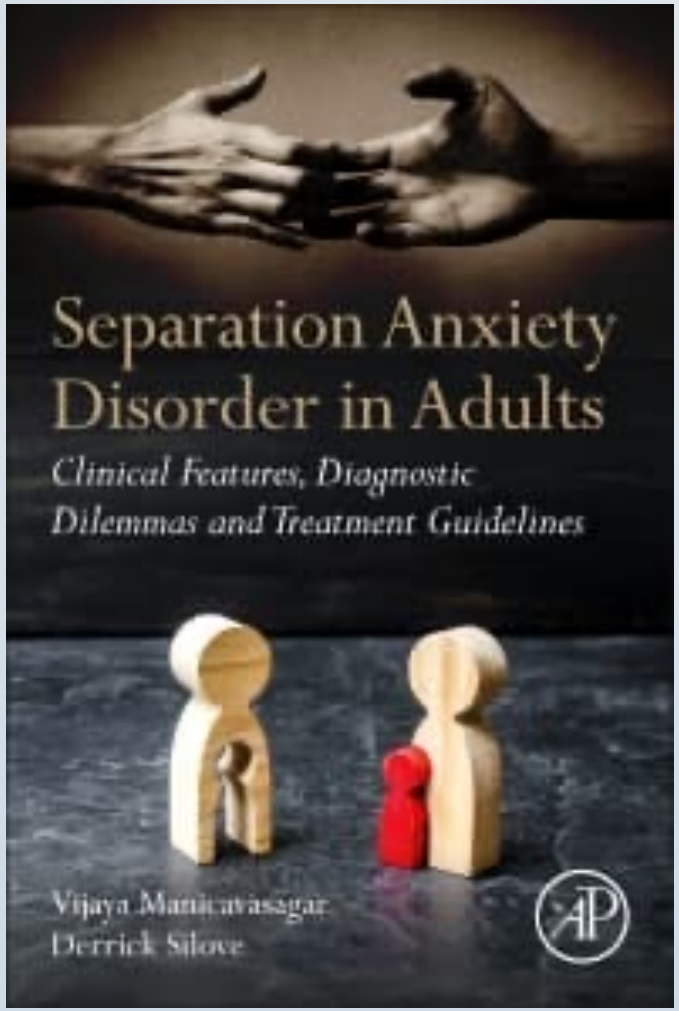
- As a clinical tool to introduce conversations about symptoms e.g. sleep rituals, fears of change in their routine, impacts on others
- To measure the level of Separation Anxiety over a specified time period (usually 4 weeks)
- To assess improvement during the course of psychological treatment
- A cutoff score or 22 is **suggestive** of a diagnosis of adult SEPAD - but this needs to be explored by clinical assessment to make a definitive diagnosis

PSYCHOMETRIC PROPERTIES OF THE ASA - 27

- A self-report measure which can be used in community and clinical populations
- Measures the severity of current SA symptoms in adults
- Cronbach's alpha 0.95; test-retest reliability 0.86
- Sensitivity=81%; Specificity=84% at a cut-off score of 22
- Items rated on a 4-point scale; total score derived by adding up the ratings on individual items

WHY IT IS IMPORTANT TO DETERMINE IF SA IS PRESENT

- Treatment response (psychological and pharmacological) to other mood and anxiety disorders will be poor if underlying SA is not addressed
- Level of functional impairment will be higher in patients with comorbid SEPAD (especially in cases of trauma and grief)
- Unaddressed heightened SA will create vulnerability to relapse for other mood and anxiety disorders
- Regardless of attachment styles, adults can manifest heightened levels of SA which, if prolonged and severe, can develop into SEPAD


Separation Anxiety Disorder in Adults
Clinical Features, Diagnostic Dilemmas and Treatment Guidelines
Vijaya Manicavasagar
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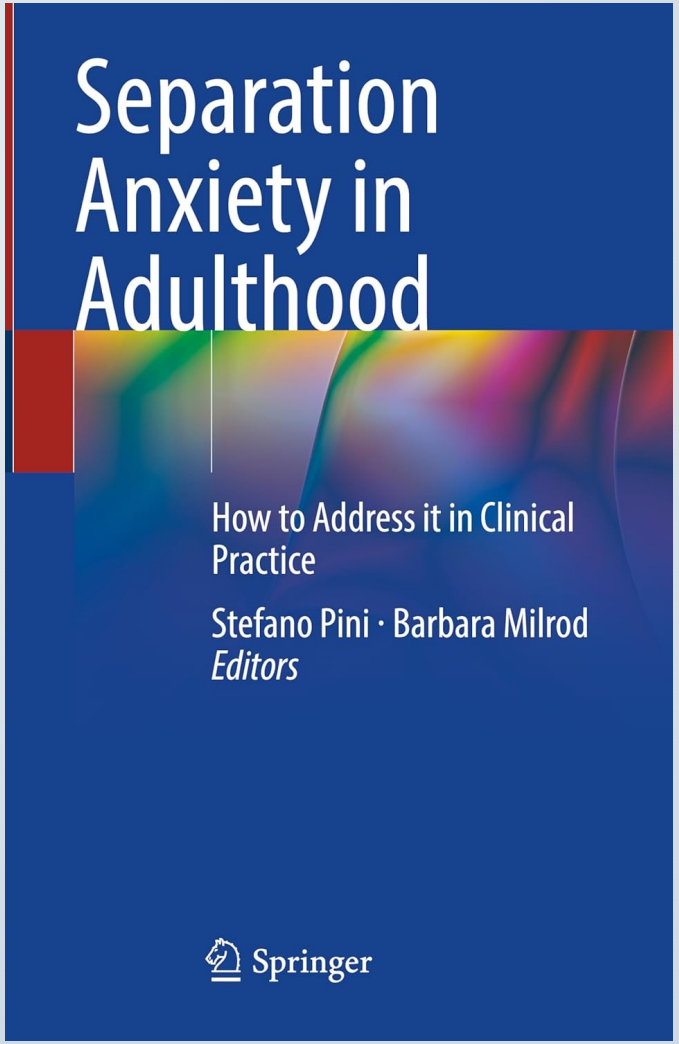
Separation Anxiety in Adulthood
How to Address it in Clinical Practice
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